Medical incapacity, legal incompetence and psychiatry

Thomas Szasz

Much of my professional career has been dedicated to showing that psychiatric coercions and excuses are incompatible with respect for individual liberty and responsibility (Szasz, 1961, 1997). Thus, I was both pleased and displeased to read the criticisms of mental health legislation by Zigmond (1998) and Szmukler & Holloway (1998). It is gratifying to see such views appear in the pages of so respected a publication as the *Psychiatric Bulletin*, the more so as no American psychiatric journal exhibits similar open-mindedness toward debating a subject that most psychiatrists consider taboo. At the same time, it is frustrating to see psychiatrists grappling with problems intrinsic to psychiatry's legal and social mandate, yet refusing to acknowledge the nature and implications of that mandate.

Psychiatry and the problem of the involuntary patient

The problems discussed by Zigmond, Szmukler & Holloway have nothing to do with what psychiatrists do when they function as the agents of their patients; they pertain solely to what they do when they function as agents of their denominated patients' adversaries. The fact that psychiatrists, unlike other physicians, systematically play such a role is the principal *raison d'être* of psychiatry. It is therefore disingenuous for Szmukler & Holloway to write, apropos of the different social roles of the medical and psychiatric patient, that "there is something odd here". Sadly, there is nothing odd here. Ever since the first innocent Englishman – or more often, Englishwoman – was confined in a private madhouse in the seventeenth century, alienists, a.k.a. psychiatrists, have been empowered by law and society's dominant ethic to imprison inconvenient individuals under the guise of medical necessity, ostensibly for the imprisoned individual's 'best interests'.

The basic interests of coercive psychiatrists and coerced patients with mental disorders either coincide, as psychiatrists and ethicists often maintain (Bloch & Chodoff, 1991), or conflict, as I maintain. If they coincide, the problem of 'psychiatric abuse' does not arise. However, if they conflict, nothing short of repealing mental health laws can protect innocent individuals from becoming the victims of psychiatric violence, justified as treatment for mental illness; and nothing short of holding persons legally accountable for their behaviour, regardless of their having an alleged mental illness, can protect people from becoming the victims of 'mental patients' whose criminal acts are excused by attributing them to mental illness.

Zigmond, Szmukler & Holloway appear to advocate equality before a law as indifferent to psychiatric status as it is to racial, religious and sexual status. Yet they propose a medical incapacity act that, in effect, not only replaces one kind of repressive mental health legislation with another but – via 'dangerousness' without 'mental illness' – extends it to the general population. As matters stand, the law treats only persons categorised as mentally ill and dangerous as wards of the state. Zigmond, Szmukler & Holloway suggest that categorising people as dangerous ought to suffice. Sayce (1998) recognises the danger this poses, asking: "Would we simply bring non-mentally ill people's rights to the same abysmal level as is currently experienced by those diagnosed mentally ill?" Most likely, we would. Clearly, we would not raise the rights and responsibilities of people diagnosed as being mentally ill to the level of persons not so diagnosed.

Sayce cogently cites a psychiatrist on prime-time British television proudly declaring "that he would rather detain nine people unnecessarily than discharge one who went on to harm a member of the public". However, she recoils from concluding that such a psychiatric–legal system is incompatible with the legal maxim of the free society dedicated to the proposition that it is better to let a thousand guilty men go free than to imprison a single innocent one. Also, she seems not to recognise that holding people who break the law who have been diagnosed as mentally ill responsible for their crimes (abolishing the insanity defence) poses an even greater problem for our society than does eschewing the practice of confining innocent persons diagnosed as being

https://doi.org/10.1192/pb.23.9.517 Published online by Cambridge University Press

mentally ill (abolishing civil commitment). We reject imprisoning innocent people. We should similarly reject hospitalising guilty people.

Preventive detention and psychiatry

Regardless of what we call it, legally sanctioned coercive detention to prevent harm to self or others is preventive detention. It is impossible to understand our love–hate relationship with this social sanction unless we appreciate that we now live in a therapeutic state (Szasz, 1989), that is, a society in which medicine and the state are united in much the same way as formerly in theological states, church and state had been united. It is the ideology of the therapeutic state that allows us to reject preventive detention as a legal–judicial abuse, and at the same time to embrace it as 'life-saving medical treatment'. The result is an ostensibly medical speciality committed to the principle of preventively imprisoning patients – to protect them from dangerous mental illness, and to protect society from the dangers 'dangerous mental patients' pose to others. Such an enterprise cannot be reformed. Either it must be abolished or it must be ceaselessly prettified, that is, reformed to conceal its congenital defects.

Most psychiatrists, including the essayists on whose contributions I am commenting, appear to agree that, "of all professional groups, psychiatrists have the most important part to play in suicide prevention" (Roy, 1986). In her philosophical foreword to Fulford's *Moral Theory and Medical Practice* (1989), Mary Warnock (1989), a distinguished British philosopher, writes:

> "Dr. Fulford defends the concept of mental illness; and he argues convincingly that there can be theoretically sound moral justification for committing the mentally ill to hospital against their wishes, in some cases."

Coercive psychiatric suicide prevention, Fulford (1989) argues:

> "shows just how compelling is the *moral intuition under which most compulsory treatment is carried out*. . . . This moral intuition, furthermore, is one which is shared worldwide . . ." (emphasis added).

Fulford's defence of psychiatric tradition and Warnock's support of it underscore that 'mental illness,' the risks of suicide–homicide and the desire to avoid them and the legal non-accountability of the mentally ill constitute a kind of psychiatric trinity, each element entailing, explaining, and justifying the other.

It is precisely the near universal belief in mental illness as a genuine disease that 'causes' or 'manifests itself through' murder and suicide, together with approval of psychiatric coercion as a rational method for preventing such deeds, that have led me to compare involuntary psychiatry to involuntary servitude, call the enterprise psychiatric slavery, and urge its abolition. Nothing less can annul the stigma of mental illness and resolve the dubious status of psychiatry as a medical speciality: 'mental illness' means 'dangerousness' (mad-ness) and *vice versa*. Hence, the person diagnosed as 'mentally ill' is burdened with a profoundly discrediting attribute. Unless the consequences of the diagnosis are radically altered, mental illness must remain an intrinsically stigmatising concept.

Dangerousness: a disease?

Unfortunately, what the contributors to the debate on the abolition of the Mental Health Act 1983 propose is a far cry from the abolition of psychiatric coercions and excuses. Szmukler & Holloway (1998) propose a "justification for non-consensual treatment for dangerousness," as if dangerousness were a disease and the non-consensual treatment of a competent person were a bona fide medical treatment. They write:

> "The justification for non-consensual treatment for dangerousness is not paternalistic. A separate framework is necessary – some kind of dangerousness legislation . . . If the person is mentally ill and treatment will eliminate or reduce the risk, a psychiatric disposal may be appropriate . . . Psychiatrists in such a system will not be required both to detain and treat people: they will be required only to treat people detained by a court. This will reduce the explicit social control function which mental health professionals now find ethically compromising."

No doubt such a policy would help psychiatrists, squeamish about depriving innocent persons of liberty. But psychiatrists do not need our help: they are free agents and hence deserve no special protections. No one is forced to be a psychiatrist. No psychiatrist is required to do anything to anyone, unless he or she freely assumes the task and responsibility – in exchange for money and prestige – to 'treat' individuals against their will. This may sound uncharitable, but is it untrue?

Human relations are either consensual or coerced. In a free society, relations among strangers, especially if they entail rendering a service in exchange for money, are based on consent. The use of force and fraud in such relations is a crime. Restoring a person's damaged car or home without his or her consent, indeed against his or her will, is an absurdity – and a criminal trespass on the property. In Anglo-American law, the involuntary medical treatment of a competent person, regardless of the alleged need for it or its beneficial effect,

https://doi.org/10.1192/pb.23.9.517 Published online by Cambridge University Press

counts as assault and battery. Nor does the law justify – except in cases of emergency with no next of kin available to give consent – the medical treatment of an incompetent person, say one who has a stroke or is unconscious as a result of an accident. Under such circumstances, the right to consent or refuse consent to treatment is delegated to the subject's guardian, if he or she has named one in an advance directive or health proxy. If the subject has not named a guardian or the guardian is unavailable, then the court appoints one. Under no circumstances can or should the doctor be both the patient's guardian and physician.

Discussion

I will not belabour my view that mental illnesses, like ghosts, are non-existent entities and that psychiatry, like slavery, rests on coercing individuals as non-persons. Such ideas and interventions are incompatible with the core values of the liberal society – treating individuals as free and responsible persons and respecting the rule of law. If we truly honoured these values, we would have to reject the twin pillars of psychiatry as an institution of social control: (a) civil commitment, a term I regard as a euphemism for depriving innocent persons of liberty – in the name of mental health; and (b) the insanity defence, a term I regard as a euphemism for diverting persons guilty of crimes from the criminal justice system to the mental health system – in the name of mental illness.

Zigmond, Szmukler & Holloway are rattling psychiatry's skeletons in the closet. That is salutary. Fulford (1998) is trying to put clothes on them. That is understandable. I propose cleaning out the closet altogether. Either we create a psychiatry as free of coercion as are dermatology, gynaecology, haematology, nephrology, neurology, oncology, ophthalmology and all other medical specialities, or we do not. *Tertium non datur.*

Acknowledgements

I wish to thank Alice Michtom, MD and Roger Yanow for help in the preparation of this paper.

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https://doi.org/10.1192/pb.23.9.517 Published online by Cambridge University Press